

ATTENDING PHYSICIAN'S SUPPLEMENTAL STATEMENT ACCIDENT OR SICKNESS

Please Answer All Questions

TO BE COMPLETED BY ATTENDING PHYSICIAN

1. DIAGNOSIS (including any complications)			
PANCREATIC ISLET CELL CANCER WITH LIVER METASTASES			
a. Diagnosis (including any complications)			
b. Subjective symptoms DIARRHEA / FATIGUE			
c. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings) ABDOMINAL SCAN			
2. DATES OF TREATMENT			
a. Date of last visit Mo. 5 Day 17 1991			
b. Frequency <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify)			
3. NATURE OF TREATMENT (Including Surgery and medications prescribed, if any)			
MONTHLY RADIATION			
4. PROGRESS			
a. Has patient <input type="checkbox"/> Recovered? <input checked="" type="checkbox"/> Improved? <input type="checkbox"/> Unchanged? <input type="checkbox"/> Retrogressed?			
b. Is patient <input checked="" type="checkbox"/> Ambulatory? <input type="checkbox"/> House Confined? <input type="checkbox"/> Bed confined? <input type="checkbox"/> Hospital confined?			
c. Has patient been hospital confined? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, give Name and Address of Hospital			
Confined from 3/12-3/15/91 through ANN- WISCONSIN - MADISON - SURGICAL			
5. CARDIAC (If Applicable)			
a. Functional capacity <input type="checkbox"/> Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation)			
<input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation)			
(American Heart Association)			
b. Blood Pressure (last visit) _____ N.A.			
systolic/diastolic			
6. RESTRICTIONS (what the patient SHOULD NOT do)			
LIMITATIONS (what the patient CANNOT do)			
7. MENTAL IMPAIRMENT (if applicable) Provide 5 AXIS Diagnosis			
I.			
II.			
III.			
IV.			
V.			
Remarks:			
8. PROGNOSIS			
a. Is patient now totally disabled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
b. What duties of patient's job is he/she incapable of performing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Do you expect a fundamental or marked change in the future?			
1. If yes, when will patient recover sufficiently to perform duties			
Mo. Day Yr. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
<input type="checkbox"/> 1 Mo. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> 1-3 Mos. <input type="checkbox"/> Never			
2. If no, please explain			
Mo. Day Yr. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
<input type="checkbox"/> 1 Mo. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> 1-3 Mos. <input type="checkbox"/> Never			
9. REHABILITATION			
a. Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)			
b. If employer can accommodate patient's limitations and restrictions is patient able to return to work?			
c. What date would employment begin?			
d. Would vocational counseling and/or retraining be recommended?			
PATIENT'S JOB <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
ANY OTHER WORK <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10. REMARKS THIS PATIENT HAS AN ISLET CELL PANCREATIC CANCER			
Physician Name (Please Print) MINASI COCHRAN MD			
Specialty medical oncologist			
Address 1800 Hollister Dr. Suite 12 City Libertyville State IL Zip 60048			
Signature (No Stamp) M Cochran			
Phone No. 847-361-6788 Fax No. 847-361-8008			
Tax ID No.			
Date 1/2/91			